Bureau for the Blind Referral for Services

PURPOSE:

This form is used as a referral to the Bureau for the Blind for;

- Financial assistance in getting needed eye care; and
- Other services available from the Bureau for the Blind.

Note: The Bureau for the Blind will not pay for services covered by the client's receipt of Medicaid.

NUMBER OF COPIES AND DISTRIBUTION:

The CSW completes two (2) copies. The original is sent to the Bureau for the Blind and a copy is retained in the case record.

INSTRUCTIONS FOR COMPLETION:

Forms should be typed or printed with black ink.

Name: Enter the full name of the person being referred.

Spouse or Parent (if Under 21): Enter the name of the spouse if the person is married. Enter the name of the parent or guardian if the person is under age 21 and is unmarried. For a foster child, enter the name of the foster parent(s).

Address: Enter the street or RR, city and zip code.

County: Enter the county in which the client resides.

Birthdate: Enter the client's birthdate.

Marital Status: Enter the client's current marital status (married, separated, divorced, widowed, or never married).

Telephone Number: Enter the current grade of a child or the last completed grade for an adult.

Is This a New Bureau Referral? Check "Yes" or "No."

Financial Information

Income Source: Enter the source of income. For a foster child, enter the source of income of the entire foster family.

Amount of Income: Enter the income amount. For a foster child, enter the income amount for the entire foster family.

Received By: Enter the name(s) of the family member(s) who receives the income.

Social Security Number: Enter the Social Security Number of the household member(s) who receive the income.

Total Monthly Income Available To Household: Enter the total gross and net (after mandatory deductions) income of all household members.

Number in Household: Enter the total number of people in the household.

Savings and Resources Other Than Home: Enter the amount of cash and securities, available personal property, and available real property owned by the household member(s). Do not include the place of residence when determining available real property.

Medical Insurance Coverage

Private Insurance, Hospital: Enter the name of any private insurance company providing hospital coverage.

Surgical: Enter the name of any private insurance company providing surgical coverage.

Title XIX (Medicaid): Check "Yes" or "No." Check "Yes" for a foster child.

Name(s) of Other Agencies Providing Services: Enter the names of other agencies helping the client and the type of services provided.

Medicaid Card Number: Enter the appropriate Medicaid Card number. For a foster child, enter the foster child's Medicaid number.

Name(s) of Other Household Members Receiving Services Through Bureau for the Blind: Enter the name(s) of all household members currently receiving Bureau for the Blind services.

Medicare: Part A and Part B - Enter "Yes" or "No."

Eye Specialist Preference: Check one of the three choices listed.

Medical Information

History of Eye Condition: Enter information received regarding the condition of the client's vision.

Name and address of Eye Care Specialist: Enter the name and address of the ophthalmologist or optometrist who last examined the client.

Date of Last Exam: Enter the approximate date of the last eye examination.

Diagnosis: Enter the diagnosis from any available medical report on the client. If no medical report is available, enter the diagnosis as stated by the client or foster parent.

Degree of Vision: Enter the visual acuity without glasses and with glasses for the right eye (R.E.) and left eye (L.E.).

Other Disabilities: Enter other physical disabilities, if applicable, as stated by the client or foster parent.

Transportation: Check "Yes" or "No."

Service(s) Needed: Enter the Bureau of the Blind services the client needs, i.e., eye exam, glasses, contact lenses or eye surgery.

Application for Services

Client's Name: The client signs the application. The parent/guardian signs the application on behalf of a minor. The CSW signs the form on behalf of a foster child.

Social Security Number: Enter the Social Security Number of the client being referred.

Date: Enter the date of the application.

Referred By: Enter the name of the CSW.

Telephone Number: Enter the County Office telephone number.

Date: Enter the date the form is completed.

Referral Source: Check "Yes" or "No."

INSTRUCTIONS FOR RETENTION

Retain this form in the case record until the entire case record is destroyed.

MEMORANDA HISTORY: CS89-90